DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

INFANT RISK SCREEN

Research supports the fact that indigent mothers and their high risk infants often need a combination of medical and non-medical services to assure positive infant health. The risk screen is designed to identify high risk infants as defined by the BabyCare program. Identify risks as listed below that apply to the client and make the appropriate referral(s). Please do not alter or add risks to the form. Additional information should be documented in the progress notes in the client's medical record.

Client Name _____ Medicaid # _____

Parent/Guardian Name _____

Client's Address _____ Phone # _____

A. MEDICAL RISKS

1. _____ Diagnosed developmentally delayed/ neurologically impaired
2. _____ Diagnosed medically significant genetic condition (including sickle cell disease)
3. _____ Birth weight - 1750 grams (3 lbs., 14 oz.) or less
4. _____ Chronic illness
5. _____ Diagnosed with fetal alcohol syndrome (FAS)
6. _____ Medical high-risk infant and pediatric care needed, but not available 24 hours a day
7. _____ Medical condition(s) the severity of which requires Care Coordination (document medical condition below)
8. _____ Born exposed to an illegal drug
9. _____ Failure to thrive or flattening of growth curve

B. SOCIAL RISKS

1. _____ Parent/guardian unable to communicate due to language barriers (e.g. non-English speaking, illiterate)
2. _____ Maternal absence (illness, incarceration, abandonment)
3. _____ Parental substance abuse/addiction (only include father if living in home)
4. _____ Caregiver's handicap presents risk to infant (physically impaired, hearing impaired, vision impaired)
5. _____ Caregiver mental illness/mental retardation
6. _____ Shelter, homeless, or migrant worker
7. _____ Mother 18 years or younger
8. _____ History of suspected abuse/or neglect
9. _____ Non-compliant with follow-up visits/screening visits and medical direction for this infant

C. NUTRITIONAL RISKS

1. _____ Congenital abnormalities affecting ability to feed or requiring special feeding techniques; poor sucking, severe or continuing diarrhea or vomiting; other conditions requiring diet modification
2. _____ Inadequate diet

REFERRAL:

1. _____ Care Coordination
2. _____ No Care Coordination
   What services will the recipient receive? _____

PROVIDER COMMENTS/SUGGESTIONS: _____

_____

PROVIDER SIGNATURE & TITLE _____ SCREENING DATE _____

NAME AND TITLE PRINTED _____ PROVIDER ID # _____

REFERRAL TO HIGH-RISK CARE COORDINATION

DMAS-17 rev. 3/03